Veterinarian/Client/Patient Relationship Validation Form

I. Producer

Producer Name:______________________________Premise ID: _________

Address:____

City:____Zip:________________

Farm Name and Location:____

Section:_____________Township:________________County:_____________

Type of Operation: (circle all that apply)

1. Farrow 2. Nursery 3. Wean to Finish 4. Finisher

II. Veterinarian

Name: Thomas A. Lang, DVM

Address: 28088 770th Ave, PO Box 30

City: Clarks Grove, Minnesota Zip: 56016

License No. C3566 USDA Accreditation No. 031834

I hereby certify that a valid Veterinarian/Client/ Patient Relationship (VCPR) is established for the above listed owner and will remain in force for one year form the signature date or until canceled by either party.

Veterinarian's Signature:_________________________Date:________________